

CLOCK HOURS

Pre-student Teaching Clinical Experience
 Participation Record and Verification

Name: _____ Student ID: _____ Semester: _____

Major (Check one):

- ECHOS Early Childhood Elementary Secondary
 Special Education Kinesiology Art Music

Major (secondary education only): _____

Name of school visited: _____

SIUE Course Name: _____

Check one: Elementary Program Early Childhood Program Secondary Education

CIED 100 Special Education: Art:
 401 402 418 300B 289 365

Music: course # _____

It is the student's responsibility to see that an accurate record of participation is maintained and that proper verification is secured. Pre-student teaching clinical experiences are required for teacher certification. At the end of the course, turn this record into SOEHHB Student Services: Founders Hall, Room 1110, Box 1062, Edwardsville, IL 62026.

Each student is encouraged to keep a copy of these hours for your own record.

DATE	TIME IN	TIME OUT	TOTAL TIME (in hours)	TEACHERS NAME (Print)	TEACHERS SIGNATURE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
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OVER

DATE	TIME IN	TIME OUT	TOTAL TIME (in hours)	TEACHERS NAME (Print)	TEACHERS SIGNATURE
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